



**State of Maine**

**Department of Health & Human Services (DHHS)**

**MaineCare**

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## **Medicaid Management Information Systems**

### ***Maine Integrated Health Management Solution Dental Services Billing Instructions Guide***

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**Maine Integrated Health Management Solution**  
**Dental Services Billing Instructions Guide**

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6.0	08/21/2015	Darcy Casey	Finalization per State acceptance email dated 08/21/2015	Final

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## 1. Introduction

This document provides billing instructions for dental services provided to MaineCare members when submitting claims for processing in the Maine Integrated Health Management Solution (MIHMS). As alternatives to paper, providers are encouraged to submit claims using the HIPAA compliant Electronic Data Interchange (EDI) 837D format, or by Direct Data Entry (DDE), which is an online process where data is directly entered into MIHMS for processing and payment. These paperless alternatives provide countless efficiencies for claims processing without the traditional problems associated with the submission of paper claims; such as getting lost in the mail, data entry errors, delayed adjudication, etc. Providers electing to use DDE or EDI must register as a Trading Partner after successful enrollment in MaineCare.

**Providers are encouraged to use these paper alternatives and may reach out for support by calling customer support at 1-866-690-5585.**

- Direct Data Entry is an option for MaineCare providers that will work well for providers who would like to submit Claims, Authorizations, and Referrals directly into MIHMS. These functions can be done one at a time, or set up using rosters to make the entry easier.
- Providers may also submit batch transaction files in the HIPAA compliant X12 EDI format.
- Additional information can be found for these billing options at the MIHMS website at: <https://mainecare.maine.gov/>.

The instructions contained in this document are to be followed for completing the claim form for the submitted dates of service to include September 1, 2010 and forward. Service dates prior to September 1, 2010 will not be processed by MIHMS, but will follow different billing instructions as specified in the MECMS billing requirements. Providers who need assistance with billing MECMS claims may contact their State Provider Relations Specialist at 1-800-321-5557.

Each provider is responsible for obtaining their own American Dental Association (ADA) 2012 forms; the Maine Department of Health and Human Services (DHHS) does not provide them.

ADA 2012 forms may be purchased pre-printed (laser-cut or continuous feed), or virtual forms may be purchased in the form of software. Forms may be purchased at office supply centers, or from other sources.

### General Guidance on Submitting Claims

**Table 1: MIHMS Provider Types**

MIHMS Provider Type	Policy Section	Rendering Provider Required	Claim Type	
			CMS1500	UB04
Dental Group	25	Yes	ADA 2012	
Dental Hygienist Group		Yes	ADA 2012	
Denturist Group		Yes	ADA 2012	
Dental Hygienist, Dentist, Denturist,		No	ADA 2012	
			CMS1500	UB04
Interpreter Services for Dental Providers	25	No	√	
Note 4: Oral Surgeons and Prosthodontics who provide services outside of Section 25 may bill MaineCare for those services using the	Non-Section 25	Yes	√	

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CMS1500				
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1. Billing instructions are intended to assist providers with the preparation of claims, and are intended to supplement the guidance provided in the applicable MaineCare Policy. Policies may be accessed at the following website:

<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

2. Paper claims will be returned to the Provider for any of the following reasons:

- Not on an original Claim Form
- The form/attachment is incorrect, not legible, print is too light, and/or the alignment is not correct (one (1) character out of alignment or more)
- Claim is damaged
- The form includes the use of any correction tape or liquid correction fluid or crossed out data
- Claim is completed with red ink
- Attachment is completed with red ink
- An attachment
  - Is not 8 ½ x 11
  - Has double sided content
- If any required fields are missing
- Federal Tax ID is less than 9 digits
- Patient's First and/or Last name are missing
- Patient's Date of Birth is missing or not in MMDDCCYY format
- Claim does not have at least one line of detail in lines 1-10
- NPI is less than 10 digits
- If Insured's ID # is not in one of these four valid formats:
  - Eight digits followed by A,
  - Eight digits followed by T,
  - Six digits preceded by T, or
  - Six digits followed by T
- Signature (typed or stamped is acceptable) and/or date is missing.

**Note:** Additionally, paper claims are translated to an EDI X12 transaction and will be returned for any HIPAA validation errors. Providers will receive a letter indicating the claim is being returned for HIPAA.

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#### 3. Codes

Use current American Dental Association (ADA)-approved codes for dental procedures from the Current Dental Terminology Manual (CDT).

Use the Procedure Codes in Chapter III of the MaineCare Benefits Manual policy section for which the billing is being performed. Access to these codes can be found at the following website:

<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

#### 4. Interpreter Services

- Dental providers must use the CMS1500 which requires a valid diagnosis code of: ICD-9 code V72.2 for claims with a date of service prior to 10/1/2015, or ICD-10 code Z01.21 or Z01.20 for claims with a date of service on or after 10/01/2015.

**NOTE:** For most claims, if a diagnosis code is present, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, if a diagnosis code is present, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code

- Codes
  - T1013 Sign language or oral interpreter services per fifteen minutes
  - T1013-GT Interpreter Services provided via documented use of Pacific Interpreters, Language Line, or equivalent telephone interpreting service, must be by report with copies of the invoice attached

#### 5. Dates

The required format for all date fields is eight digits (MMDDCCYY). (Example: October 1, 1979 = 10011979)

#### 6. Monetary amounts

- The format is dollars, decimal point, cents, with no dollar signs (or other currency indicators), and no comma separators. All amounts are in US currency.

#### 7. Multi-paged claim

- Page Total: Do not put the total claim amount on any first or intermediate page
  - The total must be placed on the last or final page of the multiple-paged claim. If the total is placed on each page, MaineCare will consider the page a stand-alone claim.
- Fill out header information on each page with identical information. This will help ensure that the claim pages are kept together.
- Other than Service Lines and Totals, only header information from page 1 will be used for actually processing the claim.
  - Attachments (e.g., operative notes) for a multiple-page claim will be placed after the last page of the claim, and the attachment(s) will be secured with a paperclip.
- Put page numbering for multi-page claims (in the format *page of total pages*) in the open area in the upper righthand area of the claim form.

#### 8. Mailing Claims

- Send or fax pre-treatment estimate requests and prior authorization requests to:  
Prior Authorization Unit  
MaineCare Services  
11 State House Station

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Augusta, ME 04333

Fax: 1-866-598-3963

- Mail the completed Dental Claim Form including replacement or reversal claims to:

MaineCare Claims Processing

M-600

Augusta, ME 04332-0011

9. Attachments and Attachment Uploads

- Attachments may be provided in any of the following ways:
  - Attach paper attachment to a paper claim
  - Attachments may be uploaded through the Portal when submitting claims via Direct Data Entry.
  - Spend down letters should be attached for each claim where the member has a coverage code of “Spend Down” for that particular date of service.
  - Attachments may be uploaded through the Portal for previously submitted claims by searching for the matching claim in Claims Status and uploading a scanned attachment directly to the claim.
    - For detailed instructions regarding uploading attachments through the Portal, refer to the appropriate MHP User Guide at the following link: <https://mainecare.maine.gov/MyHealth%20PAS%20User%20Guides/Forms/Publication%20View.aspx>
    - Acceptable file formats for upload are: PDF, GIF, JPEG/JPG, TIFF, MS Word, and MS Excel.
    - **Attachments must be submitted on the same day. If appropriate attachment is not present when the claim is being reviewed, it will deny.**

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10. Field Usage

- These instructions include description of whether each Box is Required, Situational, Optional, or Not Used, according to these definitions:
  - Required– This item must be completed with the proper information as specified.
  - Situational– This item must be completed with the proper information, if the stated triggering event applies.
  - Optional– This item can be completed at your discretion (for example, to avoid having to file claims differently for MaineCare), but if used, must contain the information as specified by the ADA guidelines, or as superseded by these instructions, if they differ.
  - Not Used– This item does not need to be completed as MaineCare/MIHMS never looks at this field.

11. Terminology

The ADA Dental form uses the term patient extensively to label boxes on the form. However, within this Billing Instructions Guide, the term “patient” may be used interchangeably with the term “member” used by MaineCare.

The ADA 2012 Dental Claim Form is shown below.

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<b>ADA American Dental Association* Dental Claim Form</b>																																																																																																																									
<b>HEADER INFORMATION</b>																																																																																																																									
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																																																																																																																									
2. Predetermination/Preauthorization Number																																																																																																																									
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>																																																																																																																									
3. Company/Plan Name, Address, City, State, Zip Code																																																																																																																									
<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b> (For Insurance Company Named in #3)																																																																																																																									
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																																																									
13. Date of Birth (MM/DD/CCYY)    14. Gender <input type="checkbox"/> M <input type="checkbox"/> F    15. Policyholder/Subscriber ID (SSN or ID#)																																																																																																																									
16. Plan/Group Number    17. Employer Name																																																																																																																									
<b>PATIENT INFORMATION</b>																																																																																																																									
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other    19. Reserved For Future Use																																																																																																																									
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																																																									
21. Date of Birth (MM/DD/CCYY)    22. Gender <input type="checkbox"/> M <input type="checkbox"/> F    23. Patient ID/Account # (Assigned by Dentist)																																																																																																																									
<b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)																																																																																																																									
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																																																																																																																									
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																																																																									
6. Date of Birth (MM/DD/CCYY)    7. Gender <input type="checkbox"/> M <input type="checkbox"/> F    8. Policyholder/Subscriber ID (SSN or ID#)																																																																																																																									
9. Plan/Group Number    10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																																																									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																																																									
<b>RECORD OF SERVICES PROVIDED</b>																																																																																																																									
<table border="1" style="width: 100%; border-collapse: collapse;"><thead><tr><th>24. Procedure Date (MM/DD/CCYY)</th><th>25. Area of Oral Cavity</th><th>26. Tooth System</th><th>27. Tooth Number(s) or Letter(s)</th><th>28. Tooth Surface</th><th>29. Procedure Code</th><th>30a. Diag. Period</th><th>30b. Qty</th><th>30. Description</th><th>31. Fee</th></tr></thead><tbody><tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>7</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>8</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>9</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table>												24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30a. Diag. Period	30b. Qty	30. Description	31. Fee	1										2										3										4										5										6										7										8										9										10									
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30a. Diag. Period	30b. Qty	30. Description	31. Fee																																																																																																																
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9																																																																																																																									
10																																																																																																																									
33. Missing Teeth Information (Place an "X" on each missing tooth.)    34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)    31a. Other Fee(s)																																																																																																																									
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16    34a. Diagnosis Code(s)    A _____ C _____    32. Total Fee																																																																																																																									
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17    (Primary diagnosis in "A")    B _____ D _____																																																																																																																									
35. Remarks																																																																																																																									
<b>AUTHORIZATIONS</b>																																																																																																																									
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.																																																																																																																									
X _____ Patient/Guardian Signature    Date _____																																																																																																																									
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.																																																																																																																									
X _____ Subscriber Signature    Date _____																																																																																																																									
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured subscriber.)																																																																																																																									
48. Name, Address, City, State, Zip Code																																																																																																																									
49. NPI    50. License Number    51. SSN or TIN																																																																																																																									
52. Phone Number ( ) -    52a. Additional Provider ID																																																																																																																									
<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>																																																																																																																									
38. Place of Treatment (e.g. 11=office; 22=OP Hospital)    39. Enclosures (Y or N) <input type="checkbox"/>																																																																																																																									
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)    41. Date Appliance Placed (MM/DD/CCYY)																																																																																																																									
42. Months of Treatment    43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)    44. Date of Prior Placement (MM/DD/CCYY)																																																																																																																									
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																																																									
46. Date of Accident (MM/DD/CCYY)    47. Auto Accident State																																																																																																																									
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>																																																																																																																									
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.																																																																																																																									
X _____ Signed (Treating Dentist)    Date _____																																																																																																																									
54. NPI    55. License Number																																																																																																																									
56. Address, City, State, Zip Code    56a. Provider Specialty Code																																																																																																																									
57. Phone Number ( ) -    58. Additional Provider ID																																																																																																																									

©2012 American Dental Association  
J430D (Same as ADA Dental Claim Form - J430, J431, J432, J433, J434)

To reorder call 800.947.4746  
or go online at [adacatalog.org](http://adacatalog.org)

Figure 1-1: ADA 2012 Claim Form

## 2. Form Instructions

The form instructions will describe how each field will be filled out including whether the field is Required, Situational, Optional, or Not Used.

### 2.1 Header Information (Type of Transaction/PA)

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
<input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization
<input type="checkbox"/> EPSDT / Title XIX
2. Predetermination/Preauthorization Number

Figure 2-1: Header Information

#### Box 1: Type of Transaction

- Required
  - Check the reason for the submission of the ADA form
    - For Claims, put an X in the box next to the Statement of Actual Services
    - For PAs, put an X in the box next to the Request for Predetermination/Preauthorization; and submit a prior authorization letter or form only when the preauthorization item is checked
    - For EPSDT program services, put an X in the box next to the EPSDT option

#### Box 2: Predetermination/Preauthorization Number

- Situational (Required for services where multiple Prior Authorizations (“PAs”) exist for the same date, service, member and provider).
  - If MaineCare Services or another agency issued prior authorization for this procedure, enter the Prior Authorization number.
  - If this procedure does not need prior authorization, leave this box blank.

### 2.2 Insurance Company/Dental Benefit Plan Information

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

Figure 2-2: Insurance Company Information

#### Box 3: Company/Plan Name, Address, City, State, Zip Code

- Optional.
  - MaineCare is assumed to be the Insurance Company.
  - The MaineCare Policyholder/Subscriber information is entered in Boxes 12 through 17. See Section 2.4, Boxes 12 through 17 for additional information.

## 2.3 Other Coverage

<b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)		
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		

Figure 2-3: Other Coverage

### Box 4: Other Dental or Medical Coverage?

- Situational
  - Mark the box after “Dental?” or “Medical?” whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage.
    - When either box is marked, items 5 through 11 in this section **are required**.
    - If both Dental and Medical are marked, enter information about the dental benefit plan in items 5 through 11.
  - If neither box is marked, items 5 through 11 in this section are not to be completed.

### Box 5: Name of Policyholder/Subscriber in #4

- Situational (required if selection is made in Box 4)
  - Enter last name, first name, middle initial and suffix.

### Box 6: Date of Birth

- Situational (required if selection is made in Box 4)
  - Enter the date of birth of the person listed in Box 5
    - Must be in MMDDCCYY format, e.g., 10011979

### Box 7: Gender

- Situational (required if selection is made in Box 4)
  - Enter the gender of the person listed in Box 5
    - Options M or F
      - M-Male
      - F-Female

### Box 8: Policyholder/Subscriber ID (SSN or ID#)

- Situational (required if selection is made in Box 4)
  - Enter the ID or social security number of the individual listed in Box 5

**Box 9: Plan/Group Number**

- Situational (required if selection is made in Box 4)
  - Enter the group plan or policy number of the individual listed in Box 5

**Box 10: Patient's Relationship to Person Named in #5**

- Situational (required if selection is made in Box 4)
  - Indicate the patient's relationship to the insured named in Box 5
    - Self
    - Spouse
    - Dependent
    - Other

**Box 11: Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**

- Situational (required if selection is made in Box 4)
  - Enter the name, group number, and address (including street, city, state and zip) of the additional payer when there is third party insurance coverage besides MaineCare

## **2.4 Policyholder/Subscriber Information**

MaineCare is assumed to be the Insurance Company for Box #3. The information in Boxes 12 through 17 references the MaineCare Policyholder/Subscriber.

<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b> (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender <div style="text-align: center;"><input type="checkbox"/> M   <input type="checkbox"/> F</div>	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

**Figure 2-4: Policyholder/Subscriber Information**

**Box 12: Policy Holder/Subscriber Name**

- Required
  - Enter the member's name exactly as it appears on the member's MaineCare eligibility card: last name, first name, and middle initial.
  - Enter the address of the MaineCare member

**Box 13: Date of Birth**

- Required
  - Enter member's date of birth

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- Must be in MMDDCCYY format, e.g., 10011979

**Box 14: Gender**

- Required
  - Options M or F

**Box 15: Policyholder/Subscriber ID**

- Required
  - Enter member's MaineCare Identification number
  - Never enter the member's SSN in Box 15; always use the MaineCare ID.
  - To verify a member's MaineCare eligibility
    - Use MyHealth PAS online portal; or
    - Submit a 270 EDI Request for Eligibility verification request
    - Use the Interactive Voice Response system (IVR).

**Box 16: Plan Group Number**

- Not Used

**Box 17: Employer Name**

- Not Used

**2.5 Patient Information**

<b>PATIENT INFORMATION</b>		
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F	23. Patient ID/Account # (Assigned by Dentist)

**Figure 2-5: Patient Information**

**Box 18: Relationship to Policyholder/Subscriber in #12 Above**

- Not Used

**Box 19: Reserved for Future Use**

- Not Used

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**Box 20: Name**

- Not Used

**Box 21: Date of Birth**

- Not Used

**Box 22: Gender**

- Not Used

**Box 23: Patient ID/Account #**

- Required
  - Enter the provider's internal patient number/identifier in this location. (Maximum length 38 but MaineCare will only return 20 characters).
  - Field may be alpha numeric
    - Examples:
      - 123456
      - Smith, John
      - Smit1234

**2.6 Record of Services Provided: Box 24 through 31: Required (unless otherwise noted)**

Repeat Boxes 24-31 for any additional services/procedures rendered, up to a total of 10 lines per claim form.

RECORD OF SERVICES PROVIDED										
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
										31a. Other Fee(s)
										32. Total Fee

**Figure 2-6: Record of Services**

**Box 24: Procedure Date**

- Situational (required if “Statement of Actual Services” or “EPSDT/Title XIX” is marked in Box 1)
  - Enter the date of the service
  - Must be in MMDDCCYY format, e.g., 09012010

**NOTE:** For most claims, if a diagnosis code is present, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, if a diagnosis code is present, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code.

### Box 25: Area of Oral Cavity

- Situational (required if procedure is related to the oral cavity)
  - Use this box to report the area of the oral cavity when the procedure is related to an oral cavity, e.g. periodontal sealing
  - Valid values are:

**Table 2: Area of Oral Cavity**

Code	Area
00	Entire oral cavity
01	Maxillary arch
02	Mandibular arch
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

### Box 26: Tooth System

- Not Used

### Box 27: Tooth Number(s) or Letter(s)

- Situational (required if procedure directly involves a tooth)
  - Must be no more than two (2) characters
  - If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form.
  - Enter the tooth number (1–32 for permanent teeth) or the tooth letter (A–T for primary teeth)
    - For tooth numbers 1–9, do not put a zero before the tooth number
  - For supernumerary tooth designation, use the following:
    - Permanent dentition: Supernumerary teeth are identified by the numbers 51–82 (add 50 to each tooth number)
      - Example: tooth 32 would be supernumerary tooth 82
    - Primary dentition: For supernumerary teeth (A–T), place the letter S after the letter of the primary tooth
      - Examples: tooth A would be AS. Tooth Q would be QS

### Box 28: Tooth Surface

- Situational (required if procedure directly involves one or more tooth surfaces (e.g. restorations)
  - Enter the appropriate letter indicating the surface of the tooth that was restored:

**Table 3: Tooth Surface**

Code	Tooth Surface
O	occlusal
M	mesial
D	distal
B	buccal

Code	Tooth Surface
L	lingual
F	facial
I	incisal

**Box 29: Procedure Code**

- Required
  - Enter the applicable CDT procedure code
  - Must be five (5) characters beginning with a “D”
  - Claims with anesthesia services beyond 45 minutes may list each additional 15 minutes distinctly on the claim form.
  - Claims for procedure code D4341:
    - must have a diagnosis for patients whose diagnosis is ICD-9 code 101 (ANUG) or ICD-10 code A69.0 (necrotizing ulcerative stomatitis) or A69.1 (other Vincent’s infections)
    - For patients who have no ICD-9 code 101 or ICD-10 codes A69.0 or A69.1 diagnosis, claims for this procedure code require Prior Authorization.

**NOTE:** For most claims, if a diagnosis code is present, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, if a diagnosis code is present, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code.

**Box 29a: Diagnosis Code Pointer**

- Situational (Required when Box 34a contains a diagnosis code)
  - Enter the letter or letters from Box 34a that identifies the diagnosis code(s) applicable to the dental procedure.
    - List the primary diagnosis pointer first.
    - Enter up to 4 letters. Do not use commas to separate the letters.
    - If this field is left blank and a diagnosis is listed in Box 34a, the system will default the diagnosis pointer to “A”.

**Box 29b: Quantity**

- Required
  - Enter the number of times (01-99) the procedure identified in Box 29 is delivered to the patient on the date of service shown in Box 24.
  - If a quantity is not populated in Box 29b, the system will default the field to ‘01’.

**Box 30: Description**

- Optional
  - Enter description of procedure according to CDT guidelines
  - **Modifiers are not allowed on the ADA2012 form**

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**Box 31: Fee**

- Required
  - Enter your fee
  - Must be in a valid currency format: dd.cc, e.g., 24.00.
  - Commas (thousands separator) may not be entered.
  - Do not put a \$ sign before the total. The \$ may be picked up as an 8.

**Box 31a: Other Fees**

- Not used
  - Data for secondary or tertiary claims will be taken and entered manually, from the information collected from the attached Explanation of Benefit (EOB), once the claim is received. It is not necessary for the provider to populate this information.
  - If billing after other insurance the EOB must be attached.
  - If the treatment is for Orthodontics, submit claim along with the primary insurance predetermination letter and primary Explanation of Benefits (EOB). Do not mark any third party payment on the claim.
  - If the treatment is for Orthodontics, and you are billing for services in addition to D8070, D8080 or D8090, the additional code must be billed on a separate claim form and include the Explanation of Benefits (EOB).

**Box 32: Total Fee**

- Required
  - Enter the total charge on the last Page of a multi-page claim
    - Claims with totals on each page will be considered as individual claims
  - Must equal the total of all lines in Box 31 for the final page of a claim
  - Must be in a valid currency format, dd.cc, e.g., 24.00
  - Commas (thousands separator) may not be entered.
  - Do not put a \$ sign before the total. The \$ may be picked up as an 8.

**2.7 Missing Teeth Information, Diagnosis Codes & Remarks**

33. Missing Teeth Information (Place an "X" on each missing tooth.)																34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)	A _____ C _____	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A")	B _____ D _____	
35. Remarks																		

**Figure 2-7: Missing Teeth Information**

**Box 33: Missing Teeth Information**

- Situational (Required for missing teeth if the procedure is related to periodontal, prosthodontic (whether fixed or removable), or implant services)
  - Place an X on the number for each corresponding missing tooth

**Box 34: Diagnosis Code List Qualifier**

- Situational (Required if a diagnosis code is listed in Box 34a)
  - Enter the appropriate code to identify the diagnosis code source.
    - ICD-9-CM: B
    - ICD-10-CM: AB

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### Box 34a: Diagnosis Code(s)

- Situational
  - A diagnosis code is required:
    - When the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.
    - On claims for procedure code D4341 for patients whose diagnosis is ICD-9 code 101 (ANUG) or ICD-10 code A69.0 (necrotizing ulcerative stomatitis) or A69.1 (other Vincent's infections). **NOTE:** for patients who have no ICD-9 code 101 or ICD-10 codes A69.0 or A69.1 diagnosis, claims for this procedure code require Prior Authorization.
  - If a diagnosis is listed in Box 34a, and Box 29a is left blank, the system will default the diagnosis pointer (Box 29a) to "A".
  - Enter the numeric International Classification of Diseases (ICD) code.
    - Use the code that is as specific as possible, according to ICD coding guidelines.
      - Do not enter the description of the diagnosis code.
    - Enter the principle diagnosis on the line after A.
    - If there is more than one diagnosis, enter each diagnosis code on the line after B., C., and D.
    - Enter no more than four diagnoses.
      - Enter the diagnosis codes most relevant to the procedure being billed.

**NOTE:** For most claims, if a diagnosis code is present, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, if a diagnosis code is present, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code

### Box 35: Remarks (Left-justified)

MISSING TEETH INFORMATION																Primary										Secondary										32. Other Fee(s)
34. (Place an 'X' on each missing tooth)																																				
35. Remarks																<div style="border: 2px solid red; padding: 5px; display: inline-block;"> <b>Box 35 Left justified NPI+3</b> </div>																				

**Figure 2-8: Box 35 Remarks - Left Justified**

- Situational (required if provider has multiple service locations)
  - The service location ID is needed **if** the provider has enrolled with more than one service location within MaineCare.
  - Service Location ID: 10 Digit NPI plus the 3 digit servicing location identifier of -001, 002, etc.(e.g., 1234567890-003)

### Box 35: Remarks (Right-justified)

35. Remarks																<div style="border: 2px solid red; padding: 5px; display: inline-block;"> <b>Box 35 right justified</b> </div>																				

**Figure 2-9: Box 35 Remarks - Right Justified**

- Situational (required when submitting an adjustment claim)

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- If this is an adjustment claim, enter one of the following on the right hand side of Box 35, followed by the claim ID from the Remittance Advice (RA)
  - 7– for Replacement of a previous claim
  - 8– for Reversal or Void

## **2.8 Authorizations**

<b>AUTHORIZATIONS</b>	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.	
X_____	_____
Patient/Guardian signature	Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	
X_____	_____
Subscriber signature	Date

**Figure 2-10: Authorizations**

### **Box 36: Patient/Guardian Signature**

- Not Used

### **Box 37: Subscriber signature**

- Not Used

## 2.9 Ancillary Claim/Treatment Information

**Box 40: if 'No' skip 41-42. If 'Yes' complete 41-42.**

**ANCILLARY CLAIM INFORMATION**

38. Place of Treatment (e.g. 11=office; 22=Outpatient Hospital)  
(Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?  
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed

**Box 39: Required when attachments are enclosed.**

42. Months of Treatment

43. Replacement of Prosthetic  
☐ No ☐ Yes

**Box 43 and 44 not used**

44. Date of Prior Placement

45. Treatment Resulting from  
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

**If 45 is checked, enter the date of accident & the two letter State abbreviation where the accident took place**

Figure 2-11: Ancillary Claim Information

### Box 38: Place of Treatment

- Required
  - Enter the appropriate two-digit place of service code(s) from the list provided.
    - Identify the location, using a place of service code, for each item used or service performed.
    - If this box is not populated, the place of service will default to '11' (office).

Table 4: Place of Service Code List

Place of Service Code List:	
01 Pharmacy	03 School
04 Homeless Shelter	05 Indian Health Service Free-standing Facility
06 Indian Health Service Provider-based Facility	07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider Based Facility	11 Office
12 Home	13 Assisted Living Facility
14 Group Home	15 Mobile Unit
17 Walk-in Retail Health Clinic	
20 Urgent Care Facility	21 Inpatient Hospital
22 Outpatient Hospital	Should be used when a provider qualifies as a "Provider Based" entity under 42CFR413.65.

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Place of Service Code List:			
23	Emergency Room – Hospital	24	Ambulatory Surgical Center
25	Birthing Center	31	Skilled Nursing Facility
32	Nursing Facility	33	Custodial Care Facility
34	Hospice	41	Ambulance – Land
42	Ambulance – Air or Water	49	Independent Clinic
50	Federally Qualified Health Center	51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization	53	Community Mental Health Center
54	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)	55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility	57	Non-Resident Substance Abuse Treatment Facility
61	Comprehensive Inpatient Rehabilitation Center	62	Comprehensive Outpatient Rehabilitation Center
65	End Stage Renal Disease Treatment Facility	71	State or Local Public Health Clinic
72	Rural Health Center	81	Independent Laboratory
		99	Other

### Box 39: Enclosures

- Required
  - Enter a “Y” or an “N” to indicate whether or not there are attachments enclosed with the ADA 2012.

### Box 40: Is the Treatment for Orthodontics?

- Required
  - Check Yes or No
  - Must have one box checked
  - If the ‘Yes’ box is checked and the member has another dental insurance:
    - Send in a copy of the predetermination letter sent by the insurance company, with the PA request, to Goold Health Systems (GHS).
    - Once the PA is received, submit claim along with the predetermination letter and primary Explanation of Benefits (EOB). Do not mark any third party payment on the claim.

### Box 41: Date Appliance Placed

- Situational (Required if Box 40 is Yes)

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- Enter the date the appliance was applied in MMDDCCYY format, e.g., 09192010

**Box 42: Months of Treatment Remaining**

- Situational (Required if Box 40 is Yes)
  - Enter total months of treatment remaining
  - Must be a number and 2 characters or less

**Box 43: Replacement of Prosthesis**

- Not Used

**Box 44: Date Prior Placement**

- Not Used

**Box 45: Treatment Resulting From**

- Situational (required if treatment for accident or occupational harm)
  - Check appropriate box if the treatment is the result of an occupational illness/injury, auto accident, or other accident
    - If box is checked, give a short description of the illness or injury

**Box 46: Date of Accident**

- Situational (required if treatment for accident or occupational harm)
  - If any box in 45 is checked enter the date of occupational illness/injury, auto, or other accident in MMDDCCYY format, e.g., 10012009

**Box 47: Auto Accident State**

- Situational (required if treatment needed for accident or occupational harm)
  - If Auto Accident box in 45 is checked, enter the two letter State abbreviation where the accident took place.
  - State abbreviations can be obtained at:  
<https://www.usps.com/send/official-abbreviations.htm>

**2.10 Billing Dentist or Dental Entity**

<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)		
48. Name, Address, City, State, Zip Code		
49. NPI	50. License Number	51. SSN or TIN
52. Phone Number (     )     -		52A. Additional Provider ID

**Figure 2-12: Billing Dentist or Entity**

**Box 48: Name, Address, City, State, Zip Code**

- Required
  - Enter the name of the billing dentist or group (as enrolled with MIHMS)
    - The provider name entered in this box is the provider name that services will be reimbursed to and should match the information supplied to AdvantageME
  - Enter the physical address of the billing dentist or group
  - A full 9-digit ZIP code is required.

**Box 49: NPI**

- Required
  - Enter the 10-digit billing provider's NPI (National Provider Identifier).
    - This is also called the Pay To NPI

**Box 50: License number**

- Optional
  - Enter the license number of the dentist or other dental professional who provided the service

**Box 51: Social Security Number (SSN) or Tax Identification Number (TIN)**

- Required
  - Enter the TAX ID or SSN number associated to the Pay To NPI

**Box 52: Phone Number**

- Optional
  - Enter phone number for billing provider

**Box 52a: Additional Provider ID**

- Not Used

**2.11 Treating Dentist and Treatment Location Information**

TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.	
X _____ Signed (Treating Dentist) Date	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code
57. Phone Number (      )      -	58. Additional Provider ID

**Figure 2-13: Treating Dentist or Location**

**Box 53: Signature or Name of Treating Dentist and Date**

- Required
  - Enter the provider's name
  - The signature may be typed or stamped. An authorized person may sign on behalf of the treating dentist. The name must be the name of an actual person
  - Do not use "signature on file"
  - Enter the month, day and year this claim form was completed using the eight-digit format MMDDCCYY, e.g. 09232010

**Box 54: NPI**

- Situational (required if a rendering provider performed the services)
  - Enter the 10-digit performing (rendering) provider's NPI (National Provider Identifier)

**Box 55: License Number (of treating dentist)**

- Optional

**Box 56: Address, City, State, Zip Code**

- Required
  - Enter the physical address for the treating provider.
  - A full 9-digit ZIP code is required.

**Box 56a: Provider Specialty Code**

- Optional
  - Enter the Specialty code associated with the NPI in Box 54

**Box 57: Phone Number**

- Optional

**Box 58: Additional Provider ID**

- Not Used

## Appendix A: Quick Reference

**Table 5: Quick Reference**

Section of Claim Form	Required	Situational	Optional / Not Used
Box 1: Type of Transaction	Required		
Box 2: Predetermination/Preauthorization Number		Situational	
Box 3: Company/Plan Name, Address, City, State, Zip Code			Optional
Box 4: Other Coverage		Situational	
Box 5: Name of Policyholder/Subscriber in #4		Situational	
Box 6: Date of Birth		Situational	
Box 7: Gender		Situational	
Box 8: Policyholder/Subscriber ID (SSN# or ID)		Situational	
Box 9: Plan/Group Number		Situational	
Box 10: Patient's Relationship to Person Named in #5		Situational	
Box 11: Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		Situational	
Box 12: Policy Holder/Subscriber Name	Required		
Box 13: Date of Birth	Required		
Box 14: Gender	Required		
Box 15: Policyholder/Subscriber ID	Required		
Box 16: Plan/Group Number			Not Used
Box 17: Employer Name			Not Used
Box 18: Relationship to Policyholder/Subscriber in #12 Above			Not Used
Box 19: Reserved for Future Use			Not Used
Box 20: Name			Not Used
Box 21: Date of Birth			Not Used
Box 22: Gender			Not Used
Box 23: Patient ID/Account #	Required		
Box 24: Procedure Date		Situational	

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Section of Claim Form	Required	Situational	Optional / Not Used
Box 25: Area of Oral Cavity		Situational	
Box 26: Tooth System			Not Used
Box 27: Tooth Number(s) or Letter(s)		Situational	
Box 28: Tooth Surface		Situational	
Box 29: Procedure Code	Required		
Box 29a: Diagnosis Code Pointer		Situational	
Box 29b: Quantity	Required		
Box 30: Description			Optional
Box 31: Fee	Required		
Box 31a: Other Fees			Not used
Box 32: Total Fee	Required		
Box 33: Missing Teeth Information		Situational	
Box 34: Diagnosis Code List Qualifier		Situational	
Box 34a: Diagnosis Code(s)		Situational	
Box 35: Remarks (Left-justified)		Situational	
Box 35: Remarks (Right-justified)		Situational	
Box 36: Patient/Guardian Signature			Not Used
Box 37: Subscriber Signature			Not Used
Box 38: Place of Treatment	Required		
Box 39: Enclosures	Required		
Box 40: Is the treatment for orthodontics?	Required		
Box 41: Date Appliance Placed		Situational	
Box 42: Months of Treatment Remaining		Situational	
Box 43: Replacement of Prosthesis?			Not Used
Box 44: Date Prior Placement			Not Used
Box 45: Treatment Resulting from		Situational	
Box 46: Date of Accident		Situational	
Box 47: Auto Accident State		Situational	
Box 48: Name, Address, City State, Zip Code	Required		
Box 49: NPI	Required		

# **Maine Integrated Health Management Solution**

## **Dental Services Billing Instructions Guide**

Section of Claim Form	Required	Situational	Optional / Not Used
Box 50: License number			Optional
Box 51: Social Security Number (SSN) or Tax Identification Number (TIN)	Required		
Box 52: Phone Number			Optional
Box 52a: Additional Provider ID			Not Used
Box 53: Signature or name of treating dentist and date	Required		
Box 54: NPI		Situational	
Box 55: License Number (of treating dentist)			Optional
Box 56: Address, City, State, Zip Code	Required		
Box 56a: Provide specialty code			Optional
Box 57: Phone Number			Optional
Box 58: Additional Provider ID			Not Used

### **Legend**

**Required** - This item must be completed with the proper information as specified.

**Situational** - This item must be completed with the proper information, if the stated triggering event applies.

**Optional** - This item can be completed at your discretion (for example, to avoid having to file claims differently for MaineCare), but if used, must contain the information specified by ADA guidelines, or these instructions, if they differ.

**Not Used** - This item need not be completed as MaineCare/MIHMS never looks at this field.